Application for License to Operate an Abortion Facility

For Administrative Use Only:

Date Received _____

Amount Received _____

I. IDENTIFICATION

Facility Name _____

Address _____

City/County/Zip _____

Telephone Number _____

Director _____

Date operation began at current address _____

Date operation began under current owner _____

II. CONTROL (Check one in each column)

Name and address of individual owner, partnership or corporation

_____

_____

_____

If owned by a corporation, attach separate sheet listing names and titles of the governing body of the corporation.

Parent Corporation (If Applicable)	Management Company (If Applicable)
_____	_____
_____	_____
_____	_____

I understand that any change in the application that affects my licensure status will be reported to the Division of Licensing and Regulation and a new application will be completed at the time.

I agree that this service and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel.

I agree to provide written agreements with an acute care hospital and a local ambulance service with this application as required by Senate Bill 217 of the 1998 Regular Session of the General Assembly.

I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

Signature of Authorized Representative	Title	Date

The annual licensure fee for an abortion facility is $155.00.

Make check payable to Kentucky State Treasurer. **DO NOT SEND CASH**.

Return application, agreements, and fee to:

Division of Licensing and Regulation
275 East Main Street, 4E-A
Frankfort, Kentucky 40621

L&R 240 (7/98)